EXPENSE REIMBURSEMENT FORM – Education / Corporate Learning

PLEASE PRINT

Employees must submit their learning expense reimbursement within 90 days of completion date

Learning Request ID (Issued by L&OD)				**Submission Checklist**		Trillium Health Partners Better Together
Name of Employee/ Payee				**Copy of Learning Request Approval Email/Notice (Required)** ☐		
Employee #				**Proof of Payment/Original Receipts** ☐		
				Proof of Attendance (grades/certification) ☐		
				Proof of Foreign Exchange (If applicable) ☐		
THP SITE:	☐ CVH ☐ MH ☐ QHC			**Phone Number:**		
Date Incurred (dd/mm/yyyy)	**Type of Expense**	**Expense Code EOC#**	**Department Name**	**Department Cost Centre**	**Expenses ($)**	**Name, Date and Provider of your Learning Event**
LEARNING & ORGANIZATIONAL DEVELOPMENT FUNDED: Only approved Learning Requests will be reimbursed for the eligible expenses.						
	REGISTRATION FEES	6103000	LEARNING & ORGANIZATIONAL DEVELOPMENT	01071-840000120		
	ACCOMMODATION / HOTEL	6241002	LEARNING & ORGANIZATIONAL DEVELOPMENT	01071-840000120		
	AIRFARE	6241003	LEARNING & ORGANIZATIONAL DEVELOPMENT	01071-840000120		
	OTHER	6241000	LEARNING & ORGANIZATIONAL DEVELOPMENT	01071-840000120		
					$	**L&OD EXPENSE AMOUNT**
DEPARTMENT (EMPLOYEE) FUNDED: Additional Expenses incurred that are ineligible for corporate learning may be expensed to your unit/department if approved by your manager. A valid EOC and department cost centre along with authorizing signature must be provided.						
	Type of Expense	**EOC #**	**Department Name**	**Department Cost Centre**		
					$	**DEPARTMENT EXPENSE AMOUNT**

Required Approver Authorization (per Hospital Signing Authority Policy)				
Learning & Organizational Development (L&OD) Use Only:	**Department Use Only: Required ONLY if submitting Department expenses:**		$	**Total KM Reimbursement (outside the GTA)**
L&OD Manager Name:	Department Manager Name:		$	**TOTAL EXPENSE CLAIM AMOUNT**
Title:	Department Manager Title:	**Claimant/Payee's Signature:** _____		
L&OD Signature:	Department Manager Signature:			

Date Approved:	Date Approved:	
This is to certify that the submitted expenses are in compliance with Hospital Expense Reimbursement Policy and **all original receipts are attached.**		This is to certify that the above expenses were incurred by me while on THP business